



Quality Strategy

Division of Quality, Evaluation,
and Health Outcomes

Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services



Driving Forces

- Documented concerns related to health care quality in the US.
- Increasing share of both Federal and State budgets directed toward the financing of Medicaid.
- Exploring options in benefit design and eligible populations alone will not ensure that payors are receiving value for the dollars spent on health care.
- States have an expectation that CMS will help provide leadership and support of Medicaid as national efforts and Alliances are becoming increasingly active and challenges to implementing improvement activities continue to exist .
- Providers and employer groups continually request that CMS join national efforts to reduce duplication in effort and administrative burden.
- Consumers are expected to participate in health care through vehicles such as consumer-directed plans, health savings accounts, and other mechanisms that will require information on cost and quality to make informed decisions.

Price and Quality Transparency.

“ The President seeks the commitment of medical providers, insurance companies, and business leaders to help consumers obtain better information on health care prices and quality. The Administration will leverage Federal resources and work with the private sector to develop meaningful measures for health care quality and to emphasize the importance of all-inclusive price information.”

Budget of the United States, FY07



Driving Forces

- **Secretary Leavitt's 500 Day Plan/250 Day Update**

Vision

- Wellness and prevention are sought as rigorously as treatment.
- Information about the quality and price of health care is widely available and Americans have a sense of ownership about choices for health care and their health.
- Inequalities in health care are eliminated.
- Medicare and Medicaid are modernized to provide high-quality health care in a financially sustainable way.
- Medicare and Medicaid beneficiaries are cost-conscious consumers.
- Medicare and Medicaid are leaders in the use of advanced technologies and performance measures.

Driving Forces



CMS Administrator FY06 Goals

- Identify and support Medicaid Best Practices.
- Incorporate the reduction of health care disparities as a priority area in the newly created Medicaid/SCHIP Quality Strategy; disseminate strategy to States, and provide information on promising practices to State Medicaid and SCHIP agencies.
- Modernize Medicare and Medicaid through the establishment of value based purchasing strategies
- Improve health care quality across Medicaid and SCHIP in accordance with the GPRA Plan of providing technical assistance to States in the areas of performance measurement, performance improvement projects, State quality strategies and external quality reporting.

CMS Quality Improvement Roadmap

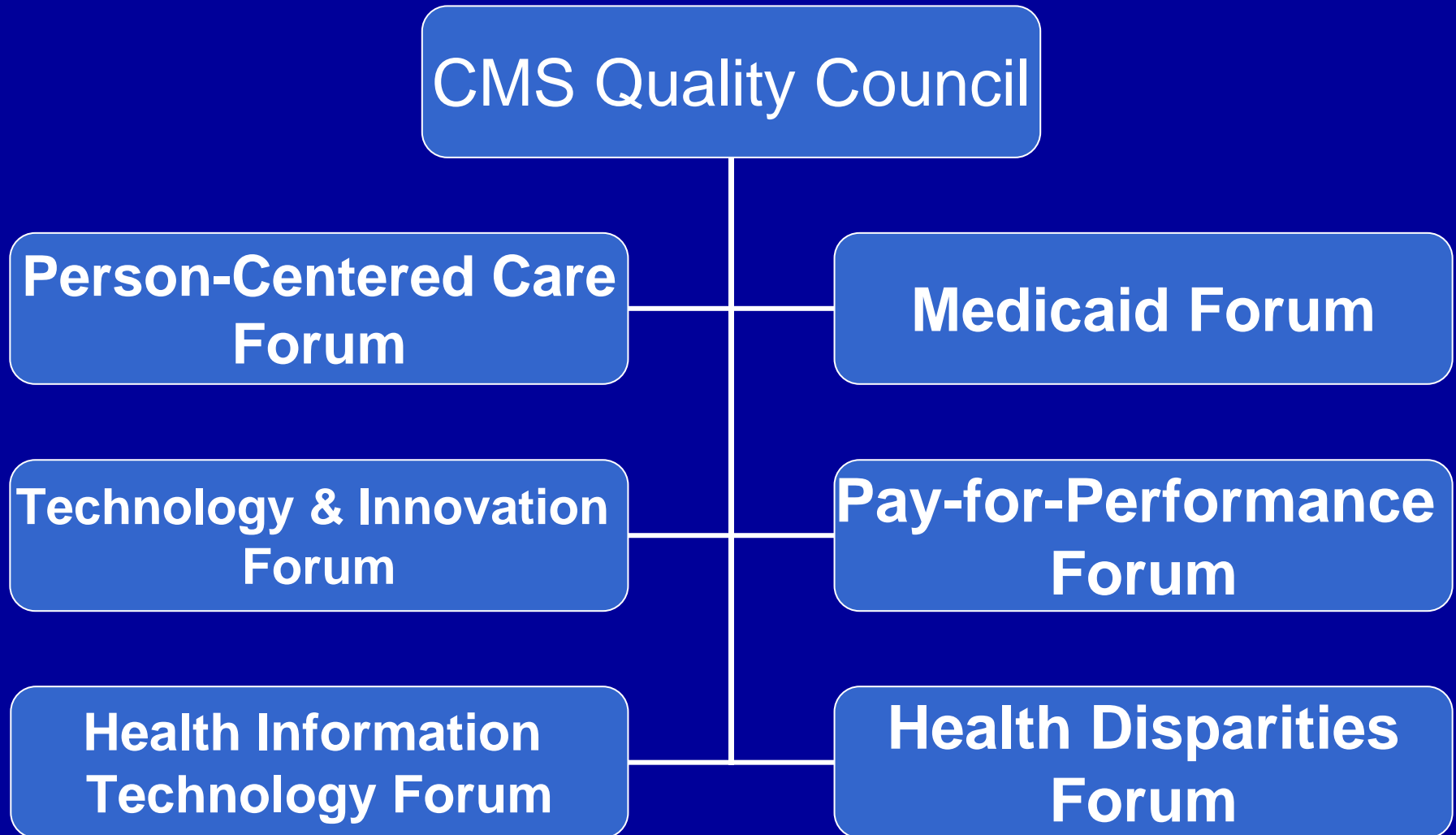
Released in August 2005

- **Vision: The right care for every person every time**



Aims:
Make care
safe,
effective,
efficient,
patient-
centered,
timely;
and
equitable 6

CMS Quality Council Forums



Medicaid/SCHIP Quality Strategy

- Created the Division of Quality, Evaluation and Health Outcomes in Spring 2005
- Developed the Medicaid/SCHIP Quality Strategy in August 2005
- Strategy builds upon the CMS Quality Roadmap and is structured to recognize the unique relationship between the Federal Government and States.
- The pillars of the Medicaid/SCHIP framework are:
 - Evidenced-Based Care and Quality Measurement
 - Supporting Value Based Payment methodologies
 - Health Information Technology
 - Partnerships
 - Information Dissemination and Technical Assistance

Evidenced Based Care and Quality Measurement

Encourage development and utilization of validated and tested measures for assessing the performance of health care providers and plans

CMSO Aims:

- Work collaboratively with States to identify available measures, gaps in measures and priorities for measures development.
- Learn from current State efforts and disseminate best practices.
- Enhance the consistency of data collection in performance measurement across payors.
- Work with States as they develop waiver applications, carry out terms and conditions, develop State quality strategies, contract for EQRO reporting, and design program evaluations.

PMPP

- CMS convened the Performance Measurement Partnership Project (PMPP) as a collaboration between Federal and State governments.
- A subsequent evaluation was done to review the States that had great depth and longevity in quality measurement, interventions and re-measurement.
- Reviewed States included:
 - Arizona
 - Arkansas
 - Colorado
 - Maine
 - Maryland
 - Michigan
 - New York
 - North Carolina
 - Ohio
 - Wisconsin

Findings

- All States studied employed HEDIS or HEDIS-like measures to assess clinical quality, and four States required external audits.
- Nine States utilized benchmarking against national NCQA MCO percentiles and nine States benchmarked against State-wide averages.
- Few States have developed State-wide baseline quality measures, implemented interventions and conducted re-measurement efforts. These efforts were most often limited to External Quality Review Organization (EQRO) activities in managed care populations.
- Two of ten States reported on FFS populations within their Medicaid program. In both cases, the States generated the FFS measures from administrative claims data. Both of these States also reported PCCM quality measures.

Findings Con't

- One State reported rolled up rates covering the State's entire Medicaid population (managed care, fee for service and primary care case management).
- All ten States reported at least one PMPP measure; two States reported all seven PMPP measures.
- Six States release only MCO information. Two States report PCCM information. One State reports on PCCM and PCCM/FFS combined. The tenth State publishes State-wide Medicaid performance measure results for their MCO/FFS/PCCM programs combined.
- The most frequently reported PMPP measures were Children's Access to PCP, Diabetes (HbA1c Testing), and Prenatal Care. In contrast, Asthma and Well Infant were least frequently reported.

Neonatal Outcomes Improvement Project

We envision a future in which low birth weight infants survive with high quality of life. We wish to reduce the disease burden as well as death rate associated with a low birth weight and prematurity. The United States has one of the highest infant mortality rates among industrialized countries. Medicaid pays a significant part of the cost associated with neonatal care.

- Antenatal Practices:
- Immediate Postnatal Practices:
- Postnatal Practices:



Neonatal Outcomes Improvement Project

- Project will move forward as a public and private partnership.
- Preliminary study reveals that interventions have the potential of greatly reducing the risk of death and respiratory distress.
- Cost savings estimates from both AHRQ and CMS indicate the potential for millions of dollars in savings between both State and Federal share.
- States that are selected to participate in the collaborative will collect data, test measures, initiate interventions and measure results.
- A public stakeholders meeting will be held in the fall to finalize the recommended measures and project design.

Supporting Efforts in Performance Based Payment

A quality improvement and reimbursement methodology which is aimed at moving towards payments that create much stronger financial support for patient focused, high value care.

- National Medicare pay-for-performance efforts underway
- Several States already have implemented performance based payment programs
- Important that evolving programs include an evaluation component to answer the question of effectiveness
- Considerations related to the approach a State uses to implement program (e.g. State Plan, Waiver, etc.)

New York State P4P

- State contracts with 28 fully capitated plans (2.6 million enrollees)
- 1115 Waiver (began 1997)
- Began P4P in the fall of 2002 to begin to make the business case for investing in quality, to accelerate improvement, and to align with other P4P initiatives (health plan initiated or private payor initiated)
- Methodology includes awarding 2/3 points for meeting goals in the HEDIS/QARR measures and 1/3 for meeting CAHPS goals.
- Plans can earn 3%, 2.25%, 1.5%, .75% or no additional premium depending on overall score. Also uses autoassignment as an incentive.

New York State P4P

- 2005 results:
 - Over \$13 million distributed to high performing plans in the first two years (02/03 and 03/04) of the program.
 - Estimated \$9.3 million to be distributed in '05
 - A pool of approximately 105,000 autoassignees who could provide high performing plans with an additional \$55 million in premium payments.
- Anticipating a grant from the Commonwealth Fund this fall for:
 - Qualitative evaluation (interviews with health plan executive staff)
 - Quantitative evaluation (using plan data to try to discern any trends)
 - Generate a report that can be used by other states/purchasers to shape their program

MARYLAND STATE PAY FOR PERFORMANCE

Table 2. Performance Summary

Performance Measure	2004 Target	MCO					
		AGM	HFC	JMS	MPC	PPMCO	UHC
		Incentive (I); Neutral (N); Disincentive (D)					
Well-child visits for children ages 3–6	Incentive: >68% Neutral: 61%–68% Disincentive: <61%	78.8% (I)	75.3% (I)	79.1% (I)	67.8% (N)	70.8% (I)	68.4% (I)
Dental services for children ages 4–20	Incentive: >60% Neutral: 40%–60% Disincentive: <40%	38.4% (D)	46.8% (N)	33.3% (D)	44.4% (N)	48.0% (N)	44.4% (N)
Ambulatory care services for SSI adults	Incentive: >86% Neutral: 72%–86% Disincentive: <72%	74.8% (N)	80.9% (N)	82.4% (N)	80.7% (N)	81.0% (N)	79.7% (N)
Ambulatory care services for SSI children	Incentive: >77% Neutral: 63%–77% Disincentive: <63%	68.0% (N)	76.3% (N)	61.0% (D)	72.8% (N)	70.6% (N)	67.4% (N)
Timeliness of prenatal care	Incentive: >89% Neutral: 72%–89% Disincentive: <72%	93.9% (I)	90.3% (I)	82.7% (N)	86.0% (N)	81.5% (N)	87.1% (N)
Cervical cancer screening for women ages 21–64	Incentive: >77% Neutral: 47%–77% Disincentive: <47%	64.5% (N)	62.8% (N)	60.1% (N)	62.8% (N)	69.1% (N)	53.5% (N)
Lead screenings for children ages 12–23 months	Incentive: >53% Neutral: 41%–53% Disincentive: <41%	50.8% (N)	54.0% (I)	48.4% (N)	50.7% (N)	51.6% (N)	43.1% (N)
Eye exams for diabetics	Incentive: >64% Neutral: 42%–64% Disincentive: <42%	50.3% (N)	38.9% (D)	62.5% (N)	41.1% (D)	40.4% (D)	50.1% (N)
Childhood immunization status—Combo 2	Incentive: >68% Neutral: 50%–68% Disincentive: <50%	80.1% (I)	73.1% (I)	75.8% (I)	66.1% (N)	75.7% (I)	65.2% (N)
Practitioner turnover	N/A	6.8%	9.2%	6.5%	2.6%	1.5%	9.4%

Quality in Community Based Services

- CMS...
 - Developed a Quality Framework
 - Provides technical assistance to States and publishes best practices
 - Is working in collaboration with AHRQ in the development of outcomes measures as specified in the DRA
 - Is working to integrate quality improvement in the Optional Choice of Self-Directed Personal Assistance Service program

Quality in Long-Term Care Services

- Nursing Home Compare
- Performance Goals
- Survey and Certification -Many Medicaid providers are subject to survey & certification under the CMS system. CMS contracts with States to carry out the surveys.
 - Nursing Homes - surveyed on average once per year.
 - ICFs-MR - surveyed once per year
 - Home Health Agencies - surveyed once every three years.



Partnerships

...collaborative efforts to improve quality of health care in areas of mutual interest

Examples of external partners with whom CMSO has met to discuss areas of potential collaboration:

- Agency for Health Research and Quality
- HHS Office of Disabilities
- National Association of Children's Hospitals
- Center for Health Care Strategies
- Child and Adolescent Health Care Initiative (CAHMI)
- National Initiative for Children's Healthcare Quality (NICHQ)
- Commonwealth Fund
- Centers for Disease Control
- Medicaid Medical Directors (AHRQ Learning Network)
- National Association of State Medicaid Directors
- National Committee for Quality Assurance
- Child and Adolescent Health Measurement Initiative

CMSO works through APHSA to convene Quality Technical Advisory Group (Q-TAG) to obtain state input on jointly defined issues

Knowledge Transfer and Information Dissemination

...use of various media to convey information to States, providers, beneficiaries, and other key Medicaid audiences for the purpose of improving quality of health care

Expect to disseminate quality-related information via:

- Issue briefs
- Analysis of demonstration evaluations
- Development of a quality website
- Conferences
- Webcasts

*The Right Care for Every
Person Every Time*